The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 7, Issue 3, DIP: 18.01.018/20190703
DOI: 10.25215/0703.018
http://www.ijip.in | July - September, 2019

The International Journal of INDIAN PSYCHOLOGY

Research Paper

Solution, Motivation and Inspiration: A Brief Understanding of Motivational Interviewing (MI)

Ms. Lakshmi Nair[1]*

ABSTRACT

Motivational Interviewing (Miller & Rollnick, 2009) is: "a collaborative, person-centred form of guiding to elicit and strengthen motivation for change." MI, is an empathic therapeutic approach that is considered to be both client-centred and directive. It is strengths-based approach which elicits peoples' motivation to change, unlike other approaches that can increase people's resistance to change. It was originally developed for use in specialised drug and alcohol treatment. In these contexts the norm was that the client received multiple MI sessions of significant duration. In the thirty years since its origin MI and various adaptions of it have been applied in health areas including smoking cessation, HIV prevention, diet and exercise, treatment adherence and gambling. This article is an attempt to collaborate the principles, skills and strategies of motivational interviewing.

Keywords: *Motivation, Therapy, Psychology, Interviewing, Techniques, Addiction*

The concept of MI grew out of a series of discussions held between a visiting scholar and a group of post-graduate psychologists at the Hjellestad Clinic in Norway in 1982. American psychologist William R. Miller had taken a sabbatical and spent 3 months at the clinic. He met the group psychologists and they discussed how Miller would respond to difficult situations they had encountered when treating people with alcohol problems. (Miller, 1995, p. 3). For Miller, the questions posed by curious colleagues provoked self-exploration that led to his writing a manuscript that outlined the ideas behind MI. He did not intend to publish the paper but sent it to a few colleagues for comment. One of them was Dr Ray Hodgson, who was then editor for Behavioural Psychotherapy. Since the whole manuscript was too long for publication the skeleton of the paper was published since the idea so important to behavioural psychotherapy and, as it turned out, to the therapeutic community at large" (Moyers, 2004, p. 294).

Miller's manuscript, "Motivational interviewing with problem drinkers", was published in the British Journal of Behavioural Psychotherapy in 1983. In the article, Miller described MI as a common sense, realistic approach based on principles derived from effective counselling practice and experience. He conceptualized motivation not as a personality trait but as part of

[1] M.Phil Clinical Psychology (Trainee), Department of Clinical Psychology, Amrita Institute of medical Science and Research Centre, Kochi, Kerala, India.
*Responding Author

Received: June 25, 2019; Revision Received: August 13, 2019; Accepted: September 25, 2019

the process of change in which contemplation and preparation are important early steps that can be influenced by the counsellor. Another key point was that confrontation in counselling tended to elicit denial and avoidance of further discussion. (Miller, Rollnick, 2009).

The next developmental leap for MI occurred in 1989, when Miller, on a holiday at the National Drug and Alcohol Research Centre in Sydney, Australia, met the British psychologist Stephen Rollnick, who was coordinating a research programme. Rollnick encouraged Miller to write more about the implementation of MI. The meeting with Rollnick prompted Miller to become more serious about describing and explaining elements of MI in greater detail. The two of them collaborated on the first book on MI, Motivational Interviewing: Preparing People to Change Addictive Behavior, which was published in 1991. The book included a description of the first principles of MI. (Moyers, 2004, p. 295)

Research and practitioner interest in MI grew steadily during the 1990s.Requests for training and evaluation soon exceed Miller and Rollnick's abilities to respond. They realized that there was a need for a pool of qualified MI trainers and decided that training teachers of MI in workshops would be the best way to promote appropriate use of the approach (Moyers, 2004). To end this, they formed Training New Trainers (TNT) and organized the first training conference in 1993 in Albuquerque, New Mexico, USA. In 1995, the Motivational Interviewing Network of Trainers (MINT) was established (MINT, 2008). The first international meeting for MI trainers was held in Malta in 1997. These meetings have alternated between Europe and America since then. The MINT network has grown each year, enrolling an influential group of clinicians, teachers, and researchers. Recent years have seen a proliferation of MI training resources, including textbooks, manuals, training video tapes, a supervision manual, and websites (Martino, Ball, Nich, Frankforter, & Carroll, 2008).

During 1990s, MI was increasingly used in various health care settings other than the treatment of addictions. This development led to the publication of a second book on MI in 1999, Health Behavior Change – A Guide for Practitioners, written by Rollnick, Mason, and Butler (1999).

In 2002, revised edition of Motivational Interviewing Preparing People for Change was published. Miller and Rollnick delayed publishing it until they felt they had a substantial body of evidence to support the efficacy and effectiveness of the approach (Moyers, 2004). The book further developed the definition and principles of MI. The first part was translated into Swedish in 2003, and was the first book on MI in Swedish.

Further books have been published; Motivational Interviewing in the Treatment of Psychological Problems by Arkowitz, Westra, Miller, and Rollnick is the first book to apply MI to mental health issues. The first world conference on MI was held Tin 2008 in Interlaken, Switzerland, attracting 222 participants from 25 countries. Hence, 25 years after Miller's original article, MI research and practice show no signs of slowing down, instead continuing to expand and following a steep diffusion curve.

WHAT IS MOTIVATIONAL INTERVIEWING(MI)

Definitions and general characteristics:

Motivational interviewing is a way of being with a client, not just a set of techniques for doing counselling (Miller, Rollnick, 1991). MI was developed in part as a reaction to patient and provider dissatisfaction with prescriptive nature of many addiction treatment approaches. (Centre For Substance Abuse Treatment 1999).

The most recent definition of Motivational Interviewing (2009) is: "a collaborative, person centred form of guiding to elicit and strengthen motivation for change."

MI is a counselling style used to support people to explore and resolve their own conflicting feelings (ambivalence) about changing health behaviours. It uses a range of listening and reflecting techniques to help people clarify their strengths and aspirations, and their motivations for change, while allowing them to make their own decisions. MI is not defined by the techniques used but by its spirit as a facilitative or guiding style.

The Motivational Interviewing Approach

Motivational Interviewing is grounded in a respectful stance with a focus on building rapport in the initial stages of the counselling relationship. A central concept of MI is the identification, examination, and resolution of ambivalence about changing behavior.

The skilful MI practitioner is adjusted to client ambivalence and "readiness for change" and thoughtfully utilizes techniques and strategies that are responsive to the client. (Rollnick, Miller, 1995).

Recent descriptions of Motivational Interviewing include three essential elements:

- ⇒ MI is a particular kind of conversation about change (counselling, therapy, consultation, method of communication)
- ⇒ MI is collaborative (person centred, partnership, , not expert recipient)
- ⇒ MI is evocative (the person's own motivation and commitment)

The "Spirit" of Motivational Interviewing

MI is more than just the use of assets of technical interventions. It is characterized by a particular "spirit" or clinical "way of being" which is the context or interpersonal relationship within which the techniques are employed.

The "Spirit of MI" is based on three key elements:
Rollnick, Miller, and Butler (2008) have defined the so-called MI spirit in terms of three key characteristics:

- ⇒ Collaboration, not confrontation, between the counsellor and client.
- ⇒ Evocation, or drawing out, the client's ideas about change.
- ⇒ Emphasizing the Autonomy of the client, versus being authoritative with them.

Collaboration (vs. Confrontation): Collaboration is a partnership between the therapist and the client, grounded in the point of view and experiences of the client. This contrasts with some other approaches to substance Use disorders treatment, which are based on the therapist assuming an "expert" role, at times confronting the client and imposing their perspective on the client's substance use behavior and the appropriate course of treatment and outcome.

Collaboration builds rapport and facilitates trust in the helping relationship, which can be challenging in a more hierarchical relationship. This does not mean that the therapist automatically agrees with the client about the nature of the problem or the changes that may be most appropriate. Although they may see things differently, the therapeutic process is focused on mutual understanding, not the therapist being right. (Rollnick et al., 2008).

Evocation (Drawing Out, Rather Than Imposing Ideas): The MI approach is one of the therapist's drawing out the individual's own thoughts and ideas, rather than imposing their opinions as motivation and commitment to change is most powerful and durable when it comes from the client. No matter what reasons the therapist might offer to convince the client of the need to change their behaviour or how much they might want the person to do so, lasting change is more likely to occur when the client discovers their own reasons and determination to change. The therapist's job is to "draw out" the person's own motivations and skills for change, not to tell them what to do or why they should do it. (Rollnick et al., 2008).

Autonomy (vs. Authority): Unlike some other treatment models that emphasize the clinician as an authority figure, Motivational Interviewing recognizes that the true power for change rests within the client. Ultimately, it is up to the individual to follow through with making changes happen. This is empowering to the individual, but also gives them responsibility for their actions. Counsellors reinforce that there is no single "right way" to change and that there are multiple ways that change can occur. In addition to deciding whether they will make a change, clients are encouraged to take the lead in developing a "menu of options' as to how to achieve the desired change.

The Principles Of Mi

MI consists of four principles that underpin its skills (Miller and Rollnick, 2002): Expression of empathy, development of discrepancy, rolling with resistance, and supporting client self-efficacy.

The expression of empathy by a counsellor is a fundamental and defining feature of MI (Miller & Rollnick, 1991). It is assumed that behaviour change is only possible when the client feels personally accepted and valued.

Empathy involves seeing the world through the client's eyes, thinking about things as the client thinks about them, feeling things as the client feels them, sharing in the client's experiences. This approach provides the basis for clients to be heard and understood, and in turn, clients are more likely to honestly share their experiences in depth. The process of expressing empathy relies on the client's experiencing the counsellor as able to see the world as they (the client) sees it. The counsellor's empathy is seen as crucial in providing the conditions necessary for a successful exploration of change to take place (Miller & Rollnick, 2002).

Developing discrepancy Motivation for change occurs when people perceive a mismatch between "where they are and where they want to be", and the therapist practicing Motivational Interviewing works to develop this by helping clients examine the discrepancies between their current circumstances/behavior and their values and future goals. When clients recognize that their current behaviours place them in conflict with their values or interfere with accomplishment of self-identified goals, they are more likely to experience increased motivation to make important life changes. It is important that the counsellor using MI does not use strategies to develop discrepancy at the expense of the other principles, yet gradually help clients to become aware of how current behaviours may lead them away from, rather than toward, their important goals. (Miller & Rollnick, 2002).

Avoidance of arguing with a client about their need for change, that is, rolling with resistance, is seen as critical in MI. It is proposed that direct confrontations about change will

provoke reactance in clients and a tendency to exhibit greater resistance, which will further reduce the likelihood of change. Clients may actively dispute the need for change, but the aim in MI is not to try to suppress clients and leave them passive recipients of a counsellor's point of view through force of argument. Instead, the MI therapist should reframe statements and invite clients to consider new information and perspectives (Miller & Rollnick, 2002).

Support for clients' self-efficacy in change is important because even if clients are motivated to modify their behaviours, change will not occur unless clients believe that they have the resources and capabilities to overcome barriers and successfully implement new ways of behaving. The MI therapist supports self-efficacy by helping clients believe in themselves and become confident that they can carry out the changes they have chosen (Miller & Rollnick, 2002).

MI Skills and Strategies

Five foundational MI skills (also known as techniques or methods) that are consistent with the principles and spirit of MI have been described by Miller & Rollnick (2002):

OARS: Often called micro counselling skills, OARS is a brief way to remember the basic approach used in Motivational Interviewing. Open Ended Questions, Affirmations, Reflections, and Summaries are core behaviours employed to move the process forward by establishing a therapeutic alliance and eliciting discussion about change.

- Asking open-ended questions
- Reflective listening
- Affirmations
- Summarizing
- Eliciting change talk

Open-ended questions are used to allow clients to do most of the talking in MI counselling sessions. Open-ended questions invite elaboration and thinking more deeply about an issue.
Although closed questions have their place and are at times valuable (e.g., when collecting specific information in an assessment), open-ended questions create forward momentum used to help the client explore the reasons for and possibility of change. Open-ended questions help clients gain better access to their true feelings and thoughts, so that they can better be recognized (Arkowitz & Miller, 2008).

eg: What made you approach the clinical psychology department?

Reflective listening from practitioners helps clients verbalize and make their meanings more explicit. This is necessary because people do not always express their thoughts clearly because of concerns or they are simply not able to find the proper words to convey their experience. It has two primary purposes. First is to bring to life the principle of Expressing Empathy. By careful listening and reflective responses, the client comes to feel that the counsellor understands the issues from their perspective. Beyond this, strategic use reflective listening is a core intervention toward guiding the client toward change, supporting the goal--directed aspect of MI. In this use of reflections, the therapist guides the client towards resolving ambivalence by a focus on the negative aspects of the status quo and the positives of making change (Miller & Rollnick, 2002).

Eg: It sounds like you ..... You are feeling... It seems to you that....
An MI counsellor should frequently affirm the client in the form of statements of appreciation or understanding in order to encourage and support the client during the change process. Affirmations are statements that recognize client strengths. They assist in building rapport and in helping the client see themselves in a different, more positive light. Affirmations often involve reframing behaviours or concerns as evidence of positive client qualities. Affirmations are a key element in facilitating the MI principle of Supporting Self-efficacy. (Miller & Rollnick, 2002).

Summaries are a special type of reflection where the therapist recaps what has occurred in all or part of a counselling session(s). Summaries communicate interest, understanding and call attention to important elements of the discussion. Summary statements are used to link and draw together the material that has been discussed, showing that the counsellor has been listening. Summaries are particularly useful to collect and reinforce change talk. Eliciting change talk is important to provide the client with a way out of their ambivalence (Miller & Rollnick, 2002).

Change talk consists of statements reflecting desire, perceived ability, need, readiness, reasons or commitment to change (Arkowitz & Miller, 2008). Change talk is found to be associated with improved client outcomes in substance abuse treatment (Amrhein et al., 2003; Baer et al., 2008; Gaume, Gmel, Faouzi, & Daeppen, 2008). Several researchers (Catley et al., 2006; Moyers & Martin, 2006) are investigating if there is a link between counsellor's MI consistent behaviour and clients' change talk. However, the body of evidence is small.

Different types of change talk can be described using the mnemonic DARN-CAT.

1. Preparatory Change Talk
2. Desire (I want to change)
3. Ability (I can change)
4. Reason (It's important to change)
5. Need (I should change)
6. are most predictive of positive outcome:
7. Implementing Change Talk
8. Commitment (I will make changes)
9. Activation (I am ready, prepared, willing to change)
10. Taking Steps (I am taking specific actions to change)

THEORETICAL INFLUENCES CONTRIBUTING TO THE DEVELOPMENT OF MI

There is no satisfactory explanation as to how and why MI can be effective. MI was not derived from theory, but rather arose from specification of principles underlying innate clinical practice (Hettema et al., 2005). MI has been criticized for essentially lacking a theoretical base (Draycott & Dabbs, 1998). Indeed, Miller and Rollnick (2002) have acknowledged that so far little attention has been paid to developing a theoretical underpinning to MI. However, although MI lacks a coherent theoretical framework, there are many theoretical influences contributing to the development of MI.

Rogers' client-centred counselling

The basis for the empathic counselling style of MI can be found in Carl Rogers' school of therapy, variously known as client- or person-centred therapy. First described in 1957, Rogers developed principles of reflective listening and believed that significant learning is only possible when the individual has confidence in his learning ability.

The main agent of change in this approach was the therapist rather than a specific treatment method (Rogers, 1959). In essence, Rogers described what is now called a therapeutic relationship (Raistrick, 2007). However, MI differs from the traditional Rogerian approach in that it is also intentionally directive in seeking to move a client towards change by selectively eliciting and strengthening the client's own reasons for change (Miller & Rollnick, 1991).

Cognitive Dissonance Theory:

MI's principle of developing discrepancy between a client's behaviours and their core values was first couched within the framework of Leon Festinger's Cognitive Dissonance Theory (Festinger, 1957). Cognitive dissonance occurs when an individual experiences some degree of discomfort resulting from an incompatibility between two cognitions or between a belief and behaviour. The theory suggests that this conflict will cause an uncomfortable psychological tension, leading people to change their beliefs to fit their behaviour instead of changing behaviours to fit their beliefs, as conventionally assumed. Dissonance theory applies to all situations involving attitude formation and change. It is especially relevant to decision-making and problem-solving (Aronson, Fried, & Stone, 1991; Cooper, 2007).

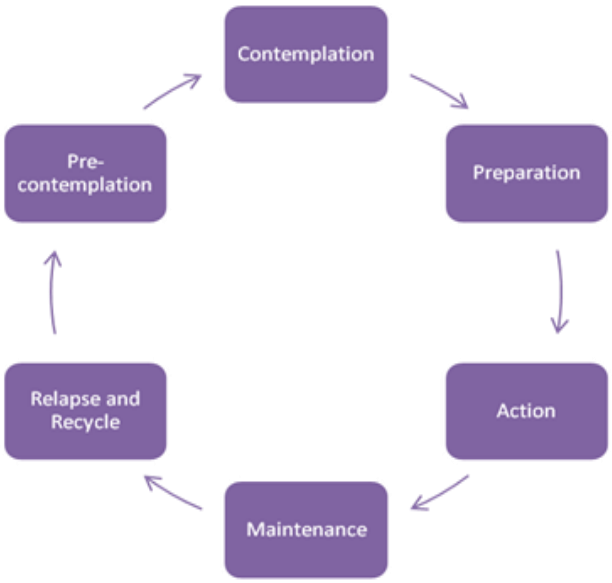
Bandura's self-efficacy concept:

The MI principle of supporting clients' self-efficacy draws on Albert Bandura's Social Learning Theory, first described in 1977. It predicts that behaviours are changed when a person perceives control over the outcome, encounters few external barriers, and feels confidence in their own ability, that is, self-efficacy (Bandura, 1986). High self-efficacy has been shown to be an important predictor of behaviour change (Armitage & Conner, 2000).

Self-Determination Theory

Self-Determination Theory has been proposed as a theoretical foundation for an better general understanding of how MI works (Markland, Ryan, Tobin, & Rollnick, 2005; Vansteenkiste & Sheldon, 2006). Self- Determination Theory focuses on independence support as a crucial determinant of optimal motivation and positive outcomes. Independence is the need to perceive oneself as the source of one's behaviour (Deci & Ryan, 2002). Autonomy support, then, is the practitioner's support of independence in the client.

Stages of change model



MI has been closely aligned with James O. Prochaska and Carlo C. DiClemente's Stages of Change model, first described in 1983 (Prochaska & DiClemente, 1983). In fact, Miller made reference to the model in his original paper on MI that same year. There are obvious similarities between MI and the Stages of Change model, although they were developed independently (Arkowitz & Miller, 2008). The Stages of Change model posits that individuals progress through five distinct stages while undergoing behavioural changes: pre-contemplation (no intention to change the behaviour in the foreseeable future); contemplation (consider making a change in the next 6 months); preparation (preparing to make a change); action (actively engaged in making a change); and maintenance (the change has been maintained for 6 months). All individuals are held to move through these changes, but it is assumed that the rate of progression will vary dramatically between individuals and behaviours (Armitage & Conner, 2000). The model gives helpful guidance in understanding the tasks that need to be accomplished for motivational and behavioural change (Raistrick, 2007).

Appropriate Motivational Strategies for Each Stage of Change	
Client's stage of change	Appropriate Motivational Strategies for the Clinician.
Precontemplation The client is not yet considering change or is unwilling or unable to change.	-Establish rapport, ask permission, and build trust. -Raise doubts or concerns in the client about substance –using pattern by: Exploring the meaning of events that brought the client to treatment or the results of previous treatments. Eliciting the client's perception of the problem. Provide personalized feedback about assessment findings. Explore the pros and cons of substance. Examining discrepancies between the client's and other's perceptions of the problem -Express concern and keep the door open.
Contemplation The client acknowledges concern and is considering the possibility of change but is ambivalent and uncertain.	-Eliciting Self motivational statements of intent and commitment from the client. -Elicit ideas regarding the client's perceived self-efficacy and expectations regarding treatment. -Summarize self-motivational statements.
Preparation The client is committed to and planning to make a change in the near future but is still considering what to do.	-Clarify the client's own goals and strategies for change. -Offer a menu of options for change or treatment. -Help the client enlist social support. -Explore treatment expectancies and the client's role. -Assist the client to negotiate finances, child care, work, transportation, or other potential barriers. -Have the client publicly announce plans to change.
Action The client is actively taking step to change but has not yet reached a stable state.	-Engage the client in treatment and reinforcement the importance of remaining in recovery. -Support a realistic view of change through small steps. -Help the client identify high risk situation and develop appropriate coping Strategies to overcome these. -Assist the client in finding new reinforces of positive change.

Maintenance The client has achieved initial goals such as abstinence and is now working to maintain gains.	-Support life style change. -Help the client practice and use new coping strategies to avoid a return to use. -Maintain support contact. -Review long term goals with the client.
Recurrence The client has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.	-Explore the meaning and reality of the recurrence as a learning opportunity. -Assist the client in finding alternative coping strategies. -Maintain supportive contact.

Miller has described MI and the Stages of Change concepts as "kissing cousins" (Rollnick, Miller & Butler, 2008). They have shared characteristics, including the approach to motivation as a process of change and the view of ambivalence as an integral part of the change process (Tober & Raistrick, 2007). However, MI is primarily concerned with the early stages of change, by resolving ambivalence for enhanced motivation in the direction of action (Arkowitz & Miller, 2008).

THE EVIDENCE BASE OF MI

The efficacy and effectiveness (the terms are often used interchangeably in studies) of MI in achieving behavioural changes have been examined in a large number of randomized controlled trials (RCT) on behavioural changes published since the late 1990s. These studies have been conducted in various settings and for a number of health-related behaviours, including alcohol, drugs, diet, exercise, and smoking. The largest body of literature concerns the use of MI to address alcohol abuse and dependence, which was the original purpose of the approach (Miller, 2004).

The 2003 meta-analysis/systematic review by Burke et al. (2003) encompassed30 RCTs of MI efficacy. Burke et al. (2003) noted that few of the MI studies could be described as being "pure MI", as they modified the method in some way, and hence should be considered adaptations of MI. However, all of the studies included in the analysis incorporated the four basic principles of MI (expressing empathy, developing discrepancy, rolling with resistance, and supporting client self efficacy). The meta-analysis showed that MI interventions were equivalent to other active treatments in terms of comparative efficacy and superior to no treatment or placebo controls for problems involving alcohol, drugs, diet, and exercise. However, there was no support for the efficacy of the interventions in the areas of smoking cessation and HIV-risk behaviours (Burke et al., 2003).
The meta-analysis/systematic review by Rubak et al. (2005) included data from 72 RCTs. Nearly two-thirds (64%) of the studies in which MI was used for counselling lasting 15 minutes or less were effective in changing behaviour. The meta-analysis demonstrated significant effects for MI for reducing body mass index, total blood cholesterol, systolic blood pressure, blood alcohol concentration, and standard ethanol content However, MI approaches were not significantly effective for reducing smoking or for reducing blood glucose levels (Rubak et al., 2005).

Suarez and Mullins (2008) published the first systematic review that investigated the effects of MI with regard to health behaviour change in paediatric populations (age 18 years and younger). Their study covered nine RCTs specific to health-related MI interventions, including diabetes, healthy eating, dental care, increased contraceptive use among adolescents and reduced second-hand smoking (studies on substance use behaviours and treatments were excluded). The authors concluded that MI appeared to be feasible for a wide

range of paediatric issues. However, they regarded the evidence for its efficacy to be preliminary. Furthermore, the breadth of behavioural domains in which there was proven effect for paediatric populations was considered limited.

Confrontational Approach and MI Approach

MI approaches differs dramatically from confrontational treatment strategies in which the therapist takes primary responsibility for "breaking down the client's denial". (Miller, p.75) provided these contrasts between approaches:

Confrontation-of- Denial approach	Motivational-Interviewing Approach
Heavy emphasis on acceptance of self as "alcoholic", acceptance of diagnosis seen as essential for change.	De-emphasis on labels; acceptance of "alcoholism" label seen as unnecessary for change to occur.
Emphasis of disease of alcoholism which reduces personal choice and control.	Emphasis on personal choice regarding future use of alcohol and other drugs.
Therapist presents perceived evidence of alcoholism in an attempt to convince the client of the diagnosis.	Therapist conducts objective evaluation but focuses on eliciting the client's own concern.
Resistance seen as "denial", a trait characteristic of alcoholics requiring confrontation	Resistance seen an interpersonal behavior pattern influenced by the therapist's behavior.
Resistance is met with arguments and correction	Resistance is met with reflection

The goal of MI therapist is to evoke statements of problem perception and need for change i.e., eliciting self-motivational statements. Eg: "What do people around you say about your drinking? What do you think are their concerns?" Miller (1989, p.75). Here the therapist does not argue with the clients, impose diagnostic label on client, tell clients what they must do, seek to break down denial by direct confrontation, Imply clients "powerlessness".

Commonalities in spirit of Acceptance and commitment therapy (ACT) and Motivational Interviewing (MI)

ACT	MI
-Therapeutic stance: therapist "sits in the same boat" as our clients. - Avoids convincing and arguing with clients. - Therapists recognize their similarities to clients. - Collaborates with client - Values the client's experience and perspective	-Empathic, collaborative approach -Handled resistance skilfully -Therapeutic style is one of calm and caring concern -Appreciate the experiences and opinions of the client -Demonstrates a genuine concern and an awareness of client's experiences -Decision making is shared -Clinician avoids arguing with client

CONCLUSION

Motivational interviewing (MI) is a tool for helping people to change - it is used to promote (or elicit) behaviour change by supporting people to explore and resolve their own conflicting feelings (ambivalence) about changing their behaviour. It uses a "guiding style" to engage with people, clarify their strengths and aspirations, evoke their own motivations for change,

and promote autonomy of decision making. MI is a useful way to work with people who are not yet thinking about change or have conflicting feelings (ambivalence) about it. These are individuals in the pre-contemplative or contemplative stages according to The Trans theoretical Model, commonly known as the Stages of Change Model (Prochaska and DiClemente, 1984). This model can be a useful way to consider a person's stage of readiness for behaviour change. This model can be a useful way to consider a person's stage of readiness for behaviour change. MI have also used in various health related behaviours, diet, exercise and smoking. Also, MI places a significant role in the personal centred approach of MET.

REFERENCES

Amrhein, P., Miller, W.R., Yahne, C.E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. Journal of Consulting and Clinical Psychology, 71, 862-878.

Arkowitz, H., & Miller, W. R. (2008). Learning, applying, and extending motivational interviewing. In: Arkowiz, H., Westra, H. A., Miller, W. R., & Rollnick, S., editors. Motivational interviewing in the treatment of psychological problems. New York: Guilford Press.

Armitage, C. J., & Conner, M. (2000). Social cognition models and health behaviour: a structured review. Psychology and Health, 15, 173–189.

Aronson, E., Fried, C., & Stone, J. (1991). Overcoming denial and increasing the intention to use condoms through the induction of hypocrisy. American Journal of Public Health, 1, 1636–1638.

Bandura, A. (1986). Social foundations of thought and action; a social cognitive theory. Englewood Cliffs; NJ: Prentice Hall.

Bergaman, J. R. (1985). Fishing for barracuda: Pragmatics for brief systemic therapy. New York: W. W. Norton.

Burke, B. L., Arkowiz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: a meta-analysis of controlled clinical trial. Journal of Consulting and Clinical Psychology, 71, 843–861.

Catley, D., Harris, K.J., Mayo, M.S., Hall, S., Okuyemi, K.S., Boardman, T., et al. (2006). Adherence to principles of motivational interviewing and client withinsession behaviour. Behavioural and Cognitive Psychotherapy, 24, 43-56.

Center for Substance Abuse Treatment (1999). Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) 35. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Deci, E. L., & Ryan, R. M. (2002). Handbook of self-determination research. Rochester, NY: The University of Rochester Press.

Draycott, S., & Dabbs, A. (1998). Cognitive dissonance 2: a theoretical grounding of motivational interviewing. British Journal of Consulting and Clinical Psychology, 37, 355–364.

Festinger, L. (1957). A theory of cognitive dissonance. Evanston, IL: Row and Peterson.

Fisch, R., Weakland, J. H., &Segal, L. (1982). Doing therapy briefly. San Francisco: Jossey-Bass

Gordon, T. (1970). Parent effectiveness training. New York: Wyden

Hettema, J., Steele, J., & Miller, W. (2005). Motivational interviewing. Annual Review of Clinical Psychology, 1, 91–111.

Kristin, workforce development director, Faculty Dominican University of California Trainer, Psychotherapist, Consultant , [PowerPoint presentation]

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. (2010). A Meta-Analysis of Motivational interviewing: Twenty-five years of empirical studies. Research on Social Work Practice, 20, 137-160.

Markland, D., Ryan, R. M., Tobin, V. J., & Rollnick, S. (2005). Motivational interviewing and self-determination theory. Journal of Social and Clinical Psychology, 24, 811–831.

Martino, S., Ball, S. A., Nich, C. A., Frankforter, T. L., & Carroll, K. (2008). Community program therapist adherence and competence in motivational enhancement therapy. Drug and Alcohol Dependence, 96, 37–48.

Miller, W. R. (1983). Motivational interviewing with problem drinkers. Behavioural Psychotherapy, 11, 147-172.

Miller, W. R., & Page, A. (1991). Warm turkey: Alternative routes to abstinence. Journal of Substance Abuse Treatment, 8, 227-232.

Miller, W. R., & Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing – preparing people for change. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. Behavioral and Cognitive Psychotherapy, 37, 129–140.

Miller, W. R., Sovereign, R. G., & Krege, B. (1988). Motivational interviewing with problem drinkers: II. The Drinker's Check-up as a preventive intervention. Behavioural Psychotherapy, 16, 251-268.

Miller, W. R., Taylor, C. A., &West, J. C. (1980). Focused versus broad spectrum behavior therapy for problem drinkers. Journal of Consulting and Clinical Psychology, 48, 590-601.

Motivational Interview (2017, February 25). Retrieved from http://makingitcount.org.uk/interventions1/motivational-interviewing

Moyers, T. B. (2004). History and happenstance: how motivational interviewing got its start. Journal of Cognitive Psychotherapy, 18, 291–298.

Polit, D. F., & Beck, C. T. (2006). Essentials of nursing research. Methods, appraisal, and utilization. 6th ed. Philadelphia, PA: Lippincott Williams & Wilkins.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of selfchange of smoking: toward an integrative model of change. Journal of Consulting and Clinical Psychology, 51, 390–395.

Punch, K. F. (1998). Introduction to social research. London: Sage.

Raistrick, D. (2007). Motivation and barriers to change. In: Tober, G., & Raistrick, D., editors. Motivational dialogue. New York: Routledge.

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centred framework. In: Koch, S., editor. Psychology: the study of science, formulations of the person and the social context (pp. 184–256). New York: McGraw-Hill.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? Behavioural and Cognitive Psychotherapy, 23, 325–334.

Rollnick, S., Mason, P., & Butler, C. (1999). Health behaviour change – a guide for practitioners. Edinburgh: Churchill Livingstone.

Rollnick, S., Mason, P., & Butler, C. (1999). Health behaviour change – a guide for practitioners. Edinburgh: Churchill Livingstone.

Rollnick, S., Miller, W. R., & Butler, C. C. (2008). Motivational interviewing in health care: helping patients change behavior. New York: Guilford Press.

Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: a systematic review and meta-analysis. British Journal of General Practice, 55, 305–312.

Suarez, M., & Mullins, S. (2008). Motivational interviewing and pediatric health behavior interventions. Journal of Development and Behavioral Pediatrics, 29, 417–428.

Tober, G., & Raistrick, D. (2007). What is motivational dialogue? In: Tober, G., & Raistrick, D., editors. Motivational dialogue. New York: Routledge.

Velasquez, M., et al.. Group Treatment for Substance Abuse. Guilford Press, 2001.

William R.M. (1995). Motivational Enhancement Therapy with Drug Abusers. Center on Alcoholism, Substance Abuse, and Addictions (CASAA). The University of New Mexico

Acknowledgements

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author declared no conflict of interests.

How to cite this article: L. Nair (2019). Solution, Motivation and Inspiration: A Brief Understanding of Motivational Interviewing (MI). *International Journal of Indian Psychology*, *7*(3), 142-154. DIP:18.01.018/20190703, DOI:10.25215/0703.018